



**NL Health Services**

Disability Management Division, Employee Wellbeing

# Initial Request for Medical Accommodation

The following information is requested to determine if the employee requires accommodation in the workplace for medical reasons. The information provided will be used to identify appropriate modifications to enable the employee to work safely in their position. Please note that the employee is responsible for payment of any fees charged for the completion of this form.

Please fax this form to **709-777-1610**.

## Section 1: MUST BE COMPLETED BY THE EMPLOYEE

<b>Employee Information (Mandatory)</b>	EMPLOYEE'S FULL NAME:		EMPLOYEE NUMBER:	DATE OF BIRTH:
	POSITION:	PROGRAM/DEPARTMENT:		EMPLOYEE'S TELEPHONE NUMBERS:
	SITE:			WORK: _____ HOME: _____
	MANAGER'S NAME:			MANAGER'S TELEPHONE NUMBER:
	I AUTHORIZE THE PHYSICIAN TO RELEASE THE INFORMATION REQUESTED BELOW TO NL HEALTH SERVICES - EASTERN ZONE'S DISABILITY MANAGEMENT DEPARTMENT.			
EMPLOYEE'S SIGNATURE: _____ DATE: _____				

## Section 2: TO BE COMPLETED BY THE PHYSICIAN / NURSE PRACTITIONER

1. What type of accommodation is requested? Please elaborate.

\_\_\_\_\_

\_\_\_\_\_

Rate the patient's functional abilities using the following:

- SLIGHT** impairment is one that causes minimal disruption and allows an individual to perform routine activities with some caution.
- MODERATE** impairment is one that allows an individual to perform routine activities with modification (slower paced). A transient increase in symptoms may result.
- SEVERE** impairment is one that an individual performs with great difficulty and some risk to self or others.

Functional Ability	Slight	Moderate	Severe
Lifting up to 10 lbs.			
Lifting up to 20 lbs.			
Lifting up to 30 lbs.			
Lifting up to 50 lbs.			
Pushing/Pulling			
Balance			
Sitting			
Bending			
Standing			
Functional Ability	Slight	Moderate	Severe
Walking			
Horizontal Reaching	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Right <input type="checkbox"/> Left
Upper Level Reaching	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Right <input type="checkbox"/> Left
Gripping or Fine Dexterity	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Right <input type="checkbox"/> Left
Squatting/Crouching			
Climbing Stairs			

**PSYCHOLOGICAL / COGNITIVE**

<input type="checkbox"/> Difficulty with detailed/complex tasks	<input type="checkbox"/> Difficulty coping with stressors	<input type="checkbox"/> Difficulty with managing time
<input type="checkbox"/> Difficulty with multitasking	<input type="checkbox"/> Difficulty with recalling instructions	<input type="checkbox"/> Difficulty dealing with confrontational issues
<input type="checkbox"/> Easily distracted, limited focus	<input type="checkbox"/> Difficulty learning new tasks	<input type="checkbox"/> Difficulty with critical decision making
<input type="checkbox"/> Difficulty dealing with public	<input type="checkbox"/> Difficulty reasoning/problem solving	<input type="checkbox"/> Cognitive fatigue

Is the patient taking any medication (prescription or non-prescription) which might impair his/her ability to do their job safely?

Yes    No   If yes, please comment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Section 3: REQUIRED TO BE COMPLETED BY PHYSICIAN / NURSE PRACTITIONER FOR ALL ACCOMMODATIONS**

1. Why is this accommodation request medically required? Please provide rationale.

\_\_\_\_\_

2. What are the current symptoms and treatment plan?

\_\_\_\_\_

3. What investigation/specialist consultations have been undertaken to establish the need for the accommodation?

\_\_\_\_\_

4. What were their conclusions and recommendations?

\_\_\_\_\_

5. Are there further investigations/consultations indicated or planned, and if so, what would that be?

\_\_\_\_\_

6. What further therapeutic measures might be undertaken to improve this condition?

\_\_\_\_\_

7. a. Do you consider the rate of progress in recovery to be satisfactory in this case?  Yes  No  
b. Are there any complications preventing recovery?

\_\_\_\_\_

8. Please estimate the period of time that is required for this accommodation:

0-3 mos.  3-6 mos.  6-12 mos.

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinic Location and Contact Number

**SECTION 3: CONSENT**

If further medical information is required in addition to above, I, \_\_\_\_\_ hereby authorize Disability Management to obtain, review or discuss information regarding my medical condition, treatment plan, and rehabilitation status and progress with my health care provider. This information is for the specific purpose of enabling Disability Management to assist me through the medical accommodation process.

\_\_\_\_\_  
Employee's Name

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

The information requested on this form is collected under the authority of the *Access to Information and Protection of Privacy Act, 2015 (SNL2015 Chapter A-1.2)* and is needed to assess your ability to return to work. Upon receipt by NL Health Services - Eastern Zone, this information will form part of your record with the Disability Management Division and will be used to document your return-to-work progress. Your information on this form will be used by relevant individuals at NL Health Services - Eastern Zone as needed and required while maintaining the strictest of confidence except as required or authorized by law. For details on the use of your information, please forward inquiries to Disability Management at 709-777-7777 3-1. If you have any questions regarding the authority to collect, use, or disclose the information, please contact NL Health Services - Eastern Zone's Privacy representative, for consultation.